ACKNOWLEDGMENT OF PATIENT INFORMATION ON ADVANCE DIRECTIVES

Name: _____

Address: _____

Social Security #: _____ Date of Birth: _____

1. I have received written information on state law, and the hospital's written policy, advising me of my right to make decisions concerning my medical care, including the right to accept or refuse medical or surgical treatment, and formulate advance directives (declaration and/or durable power of attorney for health care decisions).

☐ YES ☐ NO

2. I have formulated an advance directive:

- Declaration ☐ YES ☐ NO
- Durable Power of Attorney for Health Care Decisions ☐ YES ☐ NO

If YES is marked, I have provided a copy of my advance directive to the hospital (if I haven't, I will provide a copy to the hospital as soon as possible)

___ check here if copy is provided

Comments: (hospital follow up efforts if the patient cannot receive the advance directives information upon admission or does not bring in a copy of the advance directive if he/she states he/she has one): _____
_____
_____

Although the patient is instructed to bring in a copy of his/her advance directive to be placed in the medical record, the substance/instructions of patient's advance directive states: _____
_____
_____

I understand I will not be discriminated against on my provision of care whether or not I have an advance directive.

_____
(Patient's Signature) *(Date)*

_____
(Family or Other (if patient is unable to sign) *(Date)*

_____
(Hospital Representative) *(Date)*